MAIL TO: STATE OF ALABAMA
Workers' Compensation Division
Department of Industrial Relations
Montgomery, Alabama 36131

THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE ALABAMA WORKERS' COMPENSATION LAW, AS LAST AMENDED

SUPPLEMENTARY REPORT

Please type or print.

The original of this form must be filed with this office. Copies will not be accepted.

FIRST PAYMENT _____ **REINSTATEMENT** _____ **AMENDED** _____

1. Employee _____ 2. Social Security Number _____
3. Employer _____ 4. Unemployment Compensation Number _____
5. Date of Injury _____ 6. Date disability began this period _____
7. Insurance carrier _____ 8. Claim # _____ Service Co. # _____
9. Name, address and telephone number of office filing this report _____

_____

_____

_____

A.

10. On _____ the amount of $_____ was paid for the period from _____ thru _____
(Date of 1st check)

Average weekly wage $_____ compensation rate $_____ per week.

11. Type of disability:

Temporary total _____ ; Temporary partial _____ ; Permanent partial _____ ; Permanent total _____ ;

Fatal _____

12. If periodic payments were awarded by Circuit Court, give name, location and civil action (CV) number and explain

_____

_____

_____

B. IF COMPENSATION WAS NOT PAID WITHIN 30 DAYS FROM THE DATE DISABILITY BEGAN, COMPLETE THIS SECTION.

13. Reason for non-payment: Medical only _____ , no lost time, (return to work date) _____ ,

under investigation _____ , reason for prolonged investigation _____

_____

_____

In litigation _____ , Under Appeal _____

14. Has compensation been denied and claimant notified? Yes _____ No _____ Reason _____

_____

_____

Date _____ Signature and Title _____